



## ATRANS APPLICATION Certification of ADA Paratransit Eligibility

*Instructions: PLEASE READ CAREFULLY and remove this sheet before returning the application.*

The following information is provided to assist you in completing the attached application for paratransit service from ATRANS. Please note that eligibility is not based on a person's age. This application is divided into three sections listed below:

Policies and Procedures **KEEP this part for your records. DO NOT return this part to ATRANS.**

Part 1      Applicant Information  
Part 2      Health Care Professional Verification

- Please complete the **entire** application and return Parts 1 & 2 to ATRANS. We will contact you if the application is incomplete or have additional questions. Print clearly in ink and return the original application to ATRANS. Copies and faxes are not accepted.
- Part 2 is **ONLY** for the health care professional familiar with your disability. The application will be returned to you if anyone other than the health care professional answers. A licensed health care professional must be licensed by the state of Louisiana and may include, but is not limited to, a physician, nurse, or vocational rehabilitation counselor. **NO SOCIAL WORKERS**
- Signatures are required from all applicants or their legal guardians on the application. Also, health care professionals must include their signature.
- Allow three (3) weeks for completed applications to be processed. ATRANS will determine if you are eligible for this service and notify you by mail of our decision.
- ATRANS and the Federal Transit Administration to provide public transit services will use the information obtained in this certification. This information will be confidential and will not be provided to anyone else.
- You may contact our Eligibility Office at (318) 441-6087

Send your completed application to:  
City of Alexandria, LA - ATRANS P.O. Box 71, Alexandria LA 71309-0071



Information obtained in this certification process will only be used by ATRANS for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ WORK TELEPHONE NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING THE FIXED ROUTE SERVICE?

IS THIS CONDITION TEMPORARY?    Yes     No

IF YES, EXPECTED DURATION UNTIL: \_\_\_\_\_

HOW DOES THIS DISABILITY PREVENT YOU FROM USING FIXED ROUTE SERVICES? (Please explain completely and attach another sheet of paper if more space is needed.)

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by ATRANS.

DO YOU USE ANY OF THE FOLLOWING MOBILITY AIDS? *(Check all that apply)*

POWERED SCOOTER  CRUTCHES  CANE   
MANUAL WHEELCHAIR  ELECTRIC WHEELCHAIR   
PERSONAL CARE ATTENDANT  GUIDE DOG

OTHER (Please specify):

DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOU TRAVEL? Yes  No

IF YES, NAME OF CERTIFIED PERSONAL CARE ATTENDANT:

CAN YOU TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes  No

CAN YOU TRAVEL 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes  No

CAN YOU TRAVEL WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes  No

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE? Yes  No

CAN YOU WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES? Yes  No

**HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE  
OTHER THAN THE PERSON REQUESTING CERTIFICATION, THAT  
PERSON MUST COMPLETE THE FOLLOWING:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DAY-TIME TELEPHONE NUMBER: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_



**To the Applicant:** Sign below to allow the release of information from the professional who will be filling out this form. Once complete, return the form with your completed ADA Application.

I hereby request that information pertaining to my functional limitations be released to ATRANS, for further determination of my ADA paratransit eligibility.

**Applicant Name:** \_\_\_\_\_

**Applicant Address:** \_\_\_\_\_

**X Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**To the person filling out the form:**

This form must be filled out by a professional who is knowledgeable about the applicant's capabilities and treating the individual for the disability that prevents them from using ATRANS (i.e. physical disability should be described by a Physician, OT, PT. Etc). Please check the appropriate box for the person completing this form.

- |  |  |
|--|--|
| <input type="checkbox"/> Vocational Rehabilitation Counselor | <input type="checkbox"/> O & M instructor        |
| <input type="checkbox"/> Licensed Social Worker              | <input type="checkbox"/> Physician               |
| <input type="checkbox"/> Senior Program Director             | <input type="checkbox"/> Physical Therapist      |
| <input type="checkbox"/> Respiratory Therapist               | <input type="checkbox"/> Occupational Therapist  |
| <input type="checkbox"/> Psychologist                        | <input type="checkbox"/> Mental Health Counselor |
| <input type="checkbox"/> Psychiatrist                        | <input type="checkbox"/> Other _____             |

Please provide information regarding the disability and its impact upon the ability to utilize our transit services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests.

**Please assist us in our determination process by providing the following additional information about the applicant named above. All information will be kept confidential.**

1. What is your relationship with the applicant: \_\_\_\_\_

2. Medical Diagnosis of condition causing disability: \_\_\_\_\_

3. Is the applicant's disability temporary?  No  Yes  3-6 mo.  6-9 mo  1yr/more

If YES, expected duration until: \_\_\_\_\_

4. Is this person: (Check Y or N)

- Able to travel 200 feet without the assistance of another person?  Yes  No
- Able to travel 1/4 mile without the assistance of another person?  Yes  No
- Able to travel without the assistance of another person?  Yes  No
- Able to climb three 12 inch steps without assistance?  Yes  No
- Able to wait outside without support ten minutes?  Yes  No



5. Does this person use any mobility aids?  Yes  No

If yes what? \_\_\_\_\_

6. Visual Acuity with Best Correction:

Right Eye  Left Eye  Both

7. Visual Fields:

Right Eye  Left Eye  Both

8. Is this person able to: (Check Y or N)

- Give address and telephone number upon request?  Yes  No
- Recognize a destination or landmark?  Yes  No
- Deal with unexpected situation or changes in routine?  Yes  No
- Understand and follow directions?  Yes  No
- Safely travel through crowded complex facilities?  Yes  No

9. Is there anything other effect of the disability of which ATRANS should be aware? \_\_\_\_\_

\_\_\_\_\_

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name** \_\_\_\_\_

**Professional Title** \_\_\_\_\_

**Clinic/Agency** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_